STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

FINAL STATEMENT OF REASONS AND UPDATED INFORMATIVE DIGEST

Subject Matter of Regulations: Workers' Compensation Benefit Notices and Medical Provider Networks

Title 8, California Code of Regulations, Sections 9767.1, 9767.16, 9810, 9811, 9812, 9813, 9813.1 and 9813.2

The Administrative Director of the Division of Workers' Compensation, pursuant to the authority vested in her by Labor Code sections 59, 133, 138.3, 138.4, 139.5, 4061, 4616, 4636, 4637, 4658.5, and 5307.3, has adopted and amended regulations within Article 8, Subchapter 1 of Chapter 4.5 of Title 8, California Code of Regulations, commencing with section 9810, relating to Notices for Injuries Related to Loss of Time or Denial of Claim, and Article 3.5, Subchapter 1 of Chapter 4.5 of Title 8, California Code of Regulations, commencing with section 9767.1, relating to Medical Provider Networks.

Section 9767.1	Medical Provider Networks - Definitions
Section 9767.16	Notice of Employee Rights Upon Termination or Cessation of Use of Medical Provider Network
Section 9810	General Provisions
Section 9811	Definitions
Section 9812	Benefit Payment and Notices
Section 9813	Vocational Rehabilitation Notices
Section 9813.1	Notice of Supplemental Job Displacement Benefit and Notice of Offer of Modified or Alternative Work for Injuries Occurring on or after January 1, 2004
Section 9813.2	Return to Work Notices for Injuries Occurring on or after January 1, 2005

UPDATED INFORMATIVE DIGEST

There have been no changes in applicable laws or to the effect of the proposed regulations from the laws and effects described in the Notice of Proposed Regulatory Action.

UPDATE OF INITIAL STATEMENT OF REASONS

As authorized by Government Code §11346.9(d), the Administrative Director hereby incorporates the Initial Statement of Reasons prepared in this matter. Unless a specific basis is stated for any modification to the regulations is initially proposed, the necessity for the

amendments to existing regulations and adoption of new regulations as set forth in the Initial Statement of Reasons continue to apply to the regulations as adopted.

All modifications from the initially proposed text of the regulations are summarized below.

THE FOLLOWING SUBDIVISIONS WERE AMENDED FOLLOWING THE PUBLIC HEARING AND CIRCULATED FOR A 15-DAY COMMENT PERIOD:

1. Amendments to Existing § 9767.1: Medical Provider Networks – Definitions.

A new definition of the term "Cessation of use" was added as subdivision (a)(2): The added definition states that: "Cessation of use" means the discontinued use of an implemented MPN that continues to do business.

A new definition of the term "Termination" was added as subdivision (a)(25): The added definition states that the term "Termination" means the discontinued use of an implemented MPN that ceases to do business.

The other subdivisions were re-lettered to accommodate these additions.

These amendments were necessary to provide definitions for the regulated public and to differentiate between the terms "cessation of use" and "termination".

2. Adoption of New § 9767.16: Notice of Employee Rights Upon Termination or Cessation of Use of Medical Provider Network.

The section, as initially proposed, was modified in response to comments received.

Subdivision (a) provides that the Medical Provider Network ("MPN") Applicant is responsible for ensuring that each covered employee is informed in writing of the MPN policies under which he or she is covered and when the employee is no longer covered by an MPN. The MPN Applicant shall ensure each covered employee is given written notice of the date of termination or cessation of use of its MPN. The written notice shall be provided to covered employees prior to the effective date of termination or cessation of use of an MPN. The notices required by this section shall be made available in English and Spanish.

Subdivision (a)(1) provides that the MPN Applicant shall advise every covered employee of the following information in all notices of termination or cessation of use of an MPN by an MPN Applicant or insured employer:

- The effective date of termination or cessation of use of the MPN.
- The insurer's or employer's liability for continuing care for ongoing claims, and the potential penalties that may be imposed by the WCAB for unreasonable delay or interruption of that care.

- The name, address and telephone number of the person to contact with questions concerning the termination or cessation of use, including any questions about continuity of care or transfer of care.
- If there will be a period of no MPN coverage due to a termination, cessation of use, or before a change to a different MPN is effective, then notice shall be given of an employee's rights to a choice of physician under Labor Code section 4600. Specifically, an employee who has an existing industrial illness or injury that is being treated under the MPN shall have the right under Labor Code section 4600 to be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area after 30 days have elapsed from the date the employee notified the employer of his or her injury.
- Any pending Independent Medical Review under that MPN shall also be terminated.

Subdivision (a)(2) provides that if an MPN Applicant or insured employer is also changing MPN coverage to a different MPN, the MPN Applicant is responsible for ensuring that every covered employee is given notice of the following information in addition to the information required for an MPN termination or cessation of use:

- Notice that any injured worker receiving treatment from a provider not in the subsequent MPN, may be entitled to transfer of care to continue treatment with his or her current provider. Transfer of care applies when an employee has an acute, serious chronic or terminal illness or has a prior scheduled medical procedure with the non-MPN provider, pursuant to section 9767.9 of these regulations. The notice shall also advise that an employee may be required to treat within the new MPN after the transfer of care period.
- Notice that is required by sections 9767.12(a) and (c) for new MPN coverage and for a change of MPNs.

Subdivision (b) provides that notice of termination or cessation of use of an MPN may be combined with the notice of the change to new MPN coverage if the combined notice meets all the MPN regulatory requirements.

Subdivision (c) provides that notice of shall be transmitted by the MPN Applicant providing the new MPN coverage to the Division, not less than 45 calendar days prior to the effective date of the termination or cessation of use of the MPN. A written letter signed by the MPN Applicant's authorized individual shall be submitted to DWC stating the effective date of the termination or cessation of use of the prior MPN, the planned effective date of the new MPN coverage, and shall attach a copy of the employee notice(s) to be sent to the covered employees pursuant to this section. The notices of a change of MPNs shall not be distributed without approval from DWC. If a notice is timely filed and DWC does not act by the date the notice should be distributed, then the notice shall be deemed approved.

Subdivision (c)(1) provides that if a change in MPN coverage results in modifications to an MPN's plan application or results in the filing of a new MPN application, the MPN modification or new application filing shall be submitted to DWC pursuant to section 9767.8 or 9767.3,

whichever is applicable. Distribution to covered employees of the 30-day notice of a change of MPNs shall occur after DWC's approval of an MPN modification or new MPN.

3. Amendments to Existing § 9810: General Provisions.

Subdivision (a) was modified in response to comments received to provide that that the amended benefit notice regulations will become effective for notices required to be sent 120 days after the date of the regulations' filing with the Secretary of State.

Subdivision (c) was modified, in response to a comments received, to improve its clarity and provide that benefit notice letters may be produced on the claims administrator's letterhead, except for those notices whose language or format are set forth in statute or where a specific notice form has been adopted as a regulation.

The subdivision was also modified in response to comments received to state that a claims administrator need only provide its mailing address, and that the claims administrator's name, mailing address and telephone number need not be separately provided if the benefit notice is sent on the claims administrator's letterhead.

Finally, in order to improve its clarity, the subdivision was modified to provide that the inclusion of a notation on the notice is mandatory if any attachments are being sent with the notice. This was done by inserting the word "shall" as follows:

> All notices shall clearly identify the name and telephone number and mailing address of the individual claims examiner responsible for the payment and adjusting of the claim, and shall include a notation if one or more attachments are being sent with the notice and shall clearly state that additional information may be obtained from an Information and Assistance officer with the Division of Workers' Compensation.

Minor non-substantive grammatical changes were also made to improve the grammar of the subdivision.

Subdivision (d) was modified to improve its clarity and provides that benefit notices may be produced in any format developed by the claims administrator, except for those notices whose language or format are set forth in statute or where a specific notice form has been adopted as a regulation.

Subdivision (e) was modified, in response to a comment received, to state that a claims administrator must provide copies of all medical reports, relevant to any benefit notice issued, or which are not required to be provided along with a notice and have not yet been provided to the employee, upon the employee's request, instead of merely making available copies of any report which has not already been provided.

Subdivision (i) was modified, in response to a comment received, by adding the phrase "as appropriate" at the end of the sentence to clarify that notices in both English and Spanish are not required to be given to all claimants in all cases, but only as appropriate.

Non-substantive grammatical and typographical errors were also corrected in subdivisions (d) and (e).

4. Amendments to Existing § 9811: Definitions.

In subdivision (b), in response to comments received, the proposed deletion of the term "date of knowledge of injury" was withdrawn and the remaining subdivisions renumbered accordingly.

Subdivision (f) was modified, in response to comments received, to state that the final sentence of this subdivision should only be used in notices to employees subject to an ADR program under Labor Code section 3201.5, and then only if it is appropriate under the provisions of that ADR program.

Subdivision (f) was also modified to improve the clarity of the subdivision by inserting the word "**NOTE**" to call attention to the fact that the final sentence of this subdivision should only be used in notices to employees subject to an ADR program under Labor Code §3201.5, and then only if it is appropriate under the provisions of that ADR program.

Subdivision (i) was modified, in response to comments received, to provide that the definition of the term "Permanent and Stationary Status" applies for all dates of injury after the effective date of the regulations, and is not dependent on the existence of a ratable medical report.

5. Amendments to Existing § 9812: Benefit Payment and Notices.

Section 9812(a)(2) was modified, in response to comments received, to require notices to more accurately state the options available to an injured worker upon a **delay** in any temporary disability payment.

Where the delay is related to a medical issue, an unrepresented injured worker will be required to be advised of one of the following options:

- That if the injured worker has already received a comprehensive medical evaluation and either party disputes the results of that evaluation, the injured worker may be asked to return to that physician for a new evaluation.
- That if no comprehensive medical evaluation has taken place, the injured worker may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.1. The notice shall include the claims administrator's decision on whether the claims administrator accepts or refutes the treating physician's evaluation of the employee's temporary disability status and shall be accompanied by the form prescribed by the DWC Medical Unit with which to request assignment of a panel of Qualified Medical Evaluators. The notice shall advise the injured worker of

the 10 day time limit in which a panel may be requested and in which an appointment must be made following receipt of the panel.

In addition, the subdivision was modified, in response to comments received, to add a requirement that a notice to an unrepresented injured worker contain the following warning in not less than 12 point font at the top of the first page: You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully.

Represented injured workers will be required to be advised of one of the following options:

- That for dates of injury from January 1, 1994 through December 31, 2004, if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. That if no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.
- That for dates of injury on or after January 1, 2005, if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. That if no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.2 and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.

The final sentence of the subdivision was modified, in partial response to comments received, to state that no copy of the DWC informative pamphlet "QME/AME Fact Sheet" need be provided with an additional delay notice unless the pamphlet has been revised since it was last provided.

Section 9812(a)(3) was modified, in response to comments received, to require notices to more accurately state the options available to an injured worker upon a **denial** of any temporary disability payment.

Where the delay is related to a medical issue, an unrepresented injured worker will be required to be advised of one of the following options:

- That if the denial is based on a comprehensive medical evaluation, the injured worker may file an Application for Adjudication of Claim with the WCAB.
- That if the injured worker has already received a comprehensive medical evaluation and either party disputes the results of that evaluation, the injured worker may be asked to return to that physician for a new evaluation.

- That if no comprehensive medical evaluation has taken place, the injured worker may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.1. The notice shall include the claims administrator's decision on whether the claims administrator accepts or refutes the treating physician's evaluation of the employee's temporary disability status and shall be accompanied by the form prescribed by the DWC Medical Unit with which to request assignment of a panel of Qualified Medical Evaluators. The notice shall advise the injured worker of the 10 day time limit in which a panel may be requested and in which an appointment must be made following receipt of the panel.

In addition, the subdivision was modified, in response to comments received, to add a requirement that a notice to an unrepresented injured worker contain the following warning in not less than 12 point font at the top of the first page: You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully.

Represented injured workers will be required to be advised of one of the following options:

- That if the denial is based on a comprehensive medical evaluation, the injured worker may file an Application for Adjudication of Claim with the WCAB.
- That for dates of injury from January 1, 1994 through December 31, 2004, if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. That if no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.
- That for dates of injury on or after January 1, 2005, if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. That if no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.2 and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.

The final sentence of the subdivision was also modified, in response to comments received, to require that a copy of the relevant DWC informative pamphlet(s) “TD Fact Sheet,” “QME/AME Fact Sheet” and/or “Permanent Disability Fact Sheet” be provided with the notice, even if one has been previously provided.

Section 9812(c) was modified, in response to a comments received, to correct an erroneous reference from a changed payment “rate” to changed payment “amount.”

Section 9812(d) was modified to improve its clarity to state that if an unrepresented injured worker has already received a comprehensive medical evaluation the injured worker may only be asked to return to that physician for a new evaluation if either party disputes the results of that evaluation.

In addition, the subdivision was modified, in response to comments received, to add a requirement that a notice to an unrepresented injured worker contain the following warning in not less than 12 point font at the top of the first page: You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully.

Finally, the final sentence of the subdivision was modified to require that a copy of the relevant DWC informative pamphlet(s) "TD Fact Sheet," "QME/AME Fact Sheet" and/or "Permanent Disability Fact Sheet" be provided with the notice, even if one has been previously provided.

Section 9812(f)(2) was modified to improve its clarity to provide that if an unrepresented injured worker has already received a comprehensive medical evaluation the injured worker may only be asked to return to that physician for a new evaluation if either party disputes the results of that evaluation.

In addition, the subdivision was modified, in response to comments received, to add a requirement that a notice to an unrepresented injured worker contain the following warning in not less than 12 point font at the top of the first page: You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully.

In addition, the notice to a represented injured worker was modified to delete the reference to the Qualified Medical Evaluator being chosen from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4602.2. This is deletion was necessary because section 4602.2 was repealed.

Finally, the final sentence of the subdivision was modified to require that a copy of the DWC informative pamphlet "QME/AME Fact Sheet" be provided with the notice, even if one has been previously provided.

Section 9812(f)(3) was modified, in response to comments received, to require notices to more accurately state the options available to an injured worker upon receipt of a notice of permanent disability payment.

Unrepresented injured workers will be required to be advised of one of the following options:

- That if the denial is based on a comprehensive medical evaluation, the injured worker may file an Application for Adjudication of Claim with the WCAB.

- That if the injured worker has already received a comprehensive medical evaluation and either party disputes the results of that evaluation, the injured worker may be asked to return to that physician for a new evaluation.
- That if no comprehensive medical evaluation has taken place, the injured worker may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.1. The notice shall include the claims administrator's decision on whether the claims administrator accepts or refutes the treating physician's evaluation of the employee's temporary disability status and shall be accompanied by the form prescribed by the DWC Medical Unit with which to request assignment of a panel of Qualified Medical Evaluators. The notice shall advise the injured worker of the 10 day time limit in which a panel may be requested and in which an appointment must be made following receipt of the panel.

In addition, the subdivision was modified, in response to comments received, to add a requirement that a notice to an unrepresented injured worker contain the following warning in not less than 12 point font at the top of the first page: You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully.

Represented injured workers will be required to be advised of one of the following options:

- That if the denial is based on a comprehensive medical evaluation, the injured worker may file an Application for Adjudication of Claim with the WCAB.
- That for dates of injury from January 1, 1994 through December 31, 2004, if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. That if no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.
- That for dates of injury on or after January 1, 2005, if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. That if no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.

Section 9812(f)(4) was modified, in response to comments received, to require notices to more accurately state the options available to an injured worker upon issuance of a notice that the claims administrator alleges that no permanent disability exists.

The first paragraph of the subdivision was modified to require that if the claims administrator's determination is a medical report, a copy of the DWC informative pamphlet "QME/AME Fact Sheet" be provided with the notice, even if one has been previously provided.

Unrepresented injured workers will be required to be advised of one of the following options:

- That if the determination is based on a comprehensive medical evaluation, the injured worker may file an Application for Adjudication of Claim with the WCAB.
- That if the injured worker has already received a comprehensive medical evaluation and either party disputes the results of that evaluation, the injured worker may be asked to return to that physician for a new evaluation.
- That if no comprehensive medical evaluation has taken place, the injured worker may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.1. The notice shall include the claims administrator's decision on whether the claims administrator accepts or refutes the treating physician's evaluation of the employee's temporary disability status and shall be accompanied by the form prescribed by the DWC Medical Unit with which to request assignment of a panel of Qualified Medical Evaluators. The notice shall advise the injured worker of the 10 day time limit in which a panel may be requested and in which an appointment must be made following receipt of the panel.

In addition, the subdivision was modified, in response to comments received, to add a requirement that a notice to an unrepresented injured worker contain the following warning in not less than 12 point font at the top of the first page: You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully.

Represented injured workers will be required to be advised of one of the following options:

- That if the determination is based on a comprehensive medical evaluation, the injured worker may file an Application for Adjudication of Claim with the WCAB.
- That for dates of injury from January 1, 1994 through December 31, 2004, if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. That if no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.
- That for dates of injury on or after January 1, 2005, if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. That if no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed

Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.2 and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.

Section 9812(g)(2) was modified, in response to comments received, to correct the references to a claims administrator's "determination" of the amount of permanent disability indemnity payable to the claims administrator's "estimate" and to require that a copy of the most recent DWC informative pamphlet(s) "QME/AME Fact Sheet" and/or "Temporary Disability Fact Sheet" be provided with the notice, even if they have been previously provided.

In addition, the required notice to an unrepresented injured worker has been modified to clarify that if an unrepresented injured worker has already received a comprehensive medical evaluation the injured worker may only be asked to return to that physician for a new evaluation if either party disputes the results of that evaluation.

In addition, the subdivision was modified, in response to comments received, to add a requirement that a notice to an unrepresented injured worker contain the following warning in not less than 12 point font at the top of the first page: You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully.

The notice requirement for represented injured workers was modified to require that the injured worker be advised of one of the following options:

- That for dates of injury from January 1, 1994 through December 31, 2004, if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. That if no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.
- That for dates of injury on or after January 1, 2005, if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. That if no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.2 and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.

Subdivision (g)(2)(C) was modified, in response to comments received, to delete the phrase "State of California" in the reference to the "Disability Evaluation Unit."

Section 9812(g)(3) was modified to require that a copy of the medical report on which the claims administrator's determination of no permanent disability was based, and a copy of the most recent version of the DWC informative pamphlets, QME/AME Fact Sheet and Permanent Disability Fact Sheet be provided with the notice, even if they have been previously provided.

The subdivision was also modified, in response to comments received, to require more accurate notice to injured workers of the appropriate options available to an injured worker to challenge the claims administrator determination that no permanent disability exists.

Subdivision (3)(A) will require unrepresented injured workers to be advised of one of the following options:

- That if the determination is based on a comprehensive medical evaluation, the injured worker may file an Application for Adjudication of Claim with the WCAB.
- That if the injured worker has already received a comprehensive medical evaluation and either party disputes the results of that evaluation, the injured worker may be asked to return to that physician for a new evaluation.
- That if no comprehensive medical evaluation has taken place, the injured worker may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.1. The notice shall include the claims administrator's decision on whether the claims administrator accepts or refutes the treating physician's evaluation of the employee's temporary disability status and shall be accompanied by the form prescribed by the DWC Medical Unit with which to request assignment of a panel of Qualified Medical Evaluators. The notice shall advise the injured worker of the 10 day time limit in which a panel may be requested and in which an appointment must be made following receipt of the panel.

In addition, the subdivision was modified, in response to comments received, to add a requirement that a notice to an unrepresented injured worker contain the following warning in not less than 12 point font at the top of the first page: You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully.

Subdivision (3)(B) was modified to require that the notice advise the worker that he or she may contact an Information and Assistance office to have the treating physician's evaluation reviewed and rated by the Disability Evaluation Unit only if the denial is based upon the treating physician's report.

Represented injured workers will be required to be advised of one of the following options:

- That if the denial is based on a comprehensive medical evaluation, the injured worker may file an Application for Adjudication of Claim with the WCAB.

- That for dates of injury from January 1, 1994 through December 31, 2004, if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. That if no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.
- That for dates of injury on or after January 1, 2005, if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. That if no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.2 and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.

Subdivisions (g)(3)(B) and (C) were modified, in response to a comment received, to delete the proposed references to the "Disability Evaluation Unit as the "DWC Disability Evaluation Unit."

Section 9812(g)(4) was modified to require that a copy of the most recent version of the DWC informative pamphlet "Permanent Disability Fact Sheet" be provided with the notice, even if it has been previously provided.

The second paragraph of the subdivision was also modified, in response to comments received, to delete any references to the injured worker's acceptance or refusal of an employer's offer of regular, modified or alternative work.

Section 9812(i) was modified, in response to comments received, to more accurately state the conditions under which an injured worker may be entitled to payment of medical care under Labor Code section 5402(c).

The subdivision was modified to require that for claims reported on or after April 19, 2004, if an injured worker has filed a completed claim form with the employer, the claims administrator will be required to advise the injured worker to send for consideration of payment, all bills for medical services provided between the date the completed claim for was given to the employer and the date that liability for the claim is rejected, unless he or she has done so already. The claims administrator will also be required to advise the employee that the maximum payment for medical services that were provided consistent with the applicable treatment guidelines is $10,000.

Subdivision (j) was modified to provide that the provision with the notice to the injured worker of a copy of the most recent version of the DWC informative pamphlet "QME/AME Fact Sheet" is only required if the basis for the claims administrator's delay in determining liability is based on a medical report.

Non-substantive grammatical and typographical errors were corrected in subdivisions (d), (g)(3) and (i).

The necessity for the requirement in subdivisions (a)(2) and (3), (d)(1), (f)(2), (3) and (4), (g)(2) and (3), that various notices to an unrepresented injured worker be required to contain specific advice was statements by injured workers during the public hearing and public comment processes.

6. Amendments to Existing § 9813: Vocational Rehabilitation Notices.

Subdivision (a)(3)(C) was modified, in its final sentence, to require that a copy of the most recent version of the DWC informative pamphlet "QME/AME Fact Sheet" be provided to the injured worker with the notice, even if one has been previously provided.

Subdivision 9813(c)(4) was modified, in its final sentence, to correct a typographical error in the existing codified regulation by inserting the word "shall" as follows: "The notice shall include a DWC Form RU 103 "Request for Dispute Resolution."

7. Adoption of New § 9813.1: Notice of Supplemental Job Displacement Benefit and Notice of Offer of Modified or Alternative Work for Injuries Occurring on or after January 1, 2004.

In response to comments received, the proposed section was modified.

The words "Notice of" were added to the title in reference to the phrase "offer of modified or alternative work".

The reference to "regular" work in the section title was deleted.

In the first subdivision, now renumbered as subdivision (a), all references to the term "employer" were modified to "claims administrator."

To improve the clarity of the regulations, proposed subdivisions (2) and (4) referring respectively to the notice of regular work and the notice of alternative work, and the proposed final sentence of the section, were deleted and a new section 9813.2 was adopted to replace them.

In proposed subdivision (3), now renumbered as subdivision (b), the clause ", (where the injured worker is unable to return to their usual and customary job)" was deleted.

8. Adoption of New § 9813.2: Return to Work Notices for Injuries Occurring on or after January 1, 2005.

To improve the clarity of the Return to Work regulations, proposed subdivisions (2) and (4) of section 9813.1, referring respectively to the notice of regular work and the notice of alternative

work, and the proposed final sentence of the section, were removed from section 9813.1 and adopted as a new section.

The new section sets forth the twp possible options that should occur within 60 calendar days from the date that the condition of an injured employee with permanent partial disability becomes permanent and stationary:

Subdivision (a) provides that if an employer does not serve the employee with a notice of offer of regular work, modified work or alternative work as set forth in section 10002, each payment of permanent partial disability remaining to be paid to the employee from the date of the end of the 60 day period shall be paid in accordance with Labor Code section 4658 (d)(1) and increased by 15 percent.

Subdivision (b) provides that if an employer serves the employee with a notice of offer of regular work, modified work or alternative work as set forth in section 10002(b)(3) and (4), each payment of permanent partial disability remaining to be paid from the date the offer was served on the employee shall be paid in accordance with Labor Code section 4658 (d)(1) and decreased by 15 percent, regardless of whether the employee accepts or rejects the offer.

Subdivision (c) provides that the employer shall use Form DWC-AD 10133.53 (Section 10133.53) to offer modified or alternative work, or Form DWC-AD 10003 (Section 10003) to offer regular work. This subdivision also provides that the claims administrator may serve the offer of work on behalf of the employer.

LOCAL MANDATES DETERMINATION

- Local Mandate: None. The proposed regulations will not impose any new mandated programs or increased service levels on any local agency or school district.
- Cost to any local agency or school district that is required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code: None. The proposed amendments do not apply to any local agency or school district.
- Other nondiscretionary costs/savings imposed upon local agencies: None. The proposed amendments do not apply to any local agency or school district.

CONSIDERATION OF ALTERNATIVES

The Division considered all comments submitted during the public comment periods, and made modifications based on those comments to the regulations as initially proposed. The Administrative Director has now determined that no alternatives proposed by the regulated public or otherwise considered by the Division of Workers' Compensation would be more effective in carrying out the purpose for which these regulations were proposed, nor would they be as effective as and less burdensome to affected private persons and businesses than the regulations that were adopted.

SUMMARY OF COMMENTS RECEIVED AND RESPONSES THERETO CONCERNING THE REGULATIONS ADOPTED

The comments of each organization or individual are addressed in the charts contained in the rulemaking binder.

The public comment periods were as follows:

- Initial 45-day comment period: October 27 through December 12, 2006.
- First 15-day comment period: August 13 through August 29, 2007.
- Second 15-day comment period: September 19 through October 4, 2007.
- Third 15-day comment period: October 3 through October 18, 2007.

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